

State of California
Department of Industrial Relations
Self Insurance Plans
2265 Watt Avenue, Suite 1
Sacramento, CA 95825
Web site <http://sip.dir.ca.gov>
E-mail: sip@dir.ca.gov

PRIVATE SELF INSURER’S ANNUAL REPORT

I. GENERAL

1. CERTIFICATE NUMBER:

-

-

-

Active Revoked

2. PERIOD OF REPORT:

Full Year Interim Report for the Period of:

MonthDayYear

to

MonthDayYear

3. NAME OF MASTER CERTIFICATE HOLDER:

NAME

ADDRESS

CITYSTATEZIP + 4

State of Incorporation:

Federal Tax Identification No.:

First 4 Digits of Your Standard Industrial Classification (SIC) Code:

4. List names of ALL separate, but affiliated or subsidiary companies covered by this certificate (do not include DBAs or operating divisions):

FULL LEGAL NAME	STATE OF INCORPORATION	SUBSIDIARY/AFFILIATE CERTIFICATE NUMBER
	<div></div> <div></div>	<div></div> <div></div> <div></div> <div></div> <div>-</div> <div></div> <div></div>
	<div></div> <div></div>	<div></div> <div></div> <div></div> <div></div> <div>-</div> <div></div> <div></div>
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(Continue on reverse side of this page if necessary.)

5. During the reporting period of this report, has there been any of the following with respect to the Master Certificate Holder or any subsidiary?

(a) Reincorporating

(b) Merger

(c) Change in Identity

(d) Any additions to Self Insurance Program

YesYesYesYes

NoNoNoNo

If yes, explain:

(Continue on reverse side of this page if necessary.)

6. TO WHOM DO YOU WANT CORRESPONDENCE ADDRESSED?

NAME/TITLE:

COMPANY NAME:

ADDRESS:

CITY: STATE: ZIP+4:

TELEPHONE: () FACSIMILE (FAX) NUMBER: ()

E-MAIL ADDRESS:

SUBMIT TWO (2) COMPLETE REPORTS OF PAGES 1 THROUGH 6, INCLUDING:
• LIST OF OPEN INDEMNITY CLAIMS
• SPECIFIC EXCESS INSURANCE POLICY COVERAGE PAGE
REPORT IS DUE MARCH 1, 2001

Form A4-40a (4/92)

4. (Continued)

[illegible]

5. (Continued)

[illegible]

NOTE: Claims Administrator
Complete this page for ALL reports except
Item B Employment/Wages, which is
completed by Self Insured Employer.

II. CONSOLIDATED LIABILITIES

Certificate Number: - - -

Name of Master Certificate Holder: _____

Type of Report:

☐ Original Report (Due March each year) ☐ Amended Report ☐ Interim Report

From To
Date: Month Day Year Date: Month Day Year

A. CASES AND BENEFITS (to nearest dollar)

	Number	Incurred Liability		Paid to Date		Future Liability	
		\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
1. Cases open as of 12/31/2000 reported prior to 1996							
2. Open & Closed Cases:							
a. All cases reported in 1996							
1996 Cases open							
b. All cases reported in 1997							
1997 Cases open							
c. All cases reported in 1998							
1998 Cases open							
d. All cases reported in 1999							
1999 Cases open							
e. All cases reported in 2000							
2000 Cases open							
SUBTOTAL						\$ Indemnity	\$ Medical
3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical)						TOTAL	
						\$ Indemnity	\$ Medical
4. Total Benefits paid during 2000 (including all case expenditures):							

5. Number of MEDICAL-ONLY cases reported in 2000: _____

6. Number of INDEMNITY cases reported in 2000: _____

7. TOTAL of 5 and 6 (also entered in 2e above): _____

8. TOTAL number of open indemnity cases (all years): _____

9. Number of Fatality cases reported in 2000: _____

10. (a) Number of 2000 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 2000: _____

10. (b) Number of non-2000 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 2000: _____

B. EMPLOYMENT AND WAGES PAID IN CALENDAR YEAR 2000:

(a) NUMBER OF EMPLOYEES _____
(For which a W-2 Tax Form was issued for California employment in Calendar Year 2000)

(b) TOTAL WAGES AND SALARIES PAID \$ _____
(As reported on EDD Form DE-6 Line M for all four quarters)

IIA. ADMINISTRATOR

A. NAME OF CURRENT ADMINISTRATOR(S)/ADMINISTRATING AGENCY(S) AT THE TIME OF PREPARING THIS REPORT.

1. Name (Person)

Administrative Agency's

Agency Name

Certificate No.:

Address

or

Self Administered

City

State

Zip+4

2. Name (Person)

Administrative Agency's

Agency Name

Certificate No.:

Address

or

Self Administered

City

State

Zip+4

3. Name (Person)

Administrative Agency's

Agency Name

Certificate No.:

Address

or

Self Administered

City

State

Zip+4

4. Name (Person)

Administrative Agency's

Agency Name

Certificate No.:

Address

or

Self Administered

City

State

Zip+4

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD? YES NO IF YES, DATE OF CHANGE:

TYPE OF CHANGE:

Change in Administrative Agency

Change to or from Self Administration

C. NAME OF PRIOR ADMINISTRATOR(S)/ADMINISITRATIVE AGENCY(S):

Name

Agency Name

Address

City

State

Zip+4

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this consolidated report of this self insurer’s workers’ compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers’ compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers’ compensation claims made in this report reflect the administrator’s best judgment as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

Original Signature of Administrator (Person)

Date

Typed Name of Administrator

Name of Administrative Agency or Employer

Title

Street Address

City

State

Zip+4

Phone No. of Administrator ()

FAX No. ()

area code

area code

E-mail Address of Administrator

NOTE: Claims Administrator
Complete this page for *each adjusting*
location where there are at least
two adjusting locations.

III. LIABILITIES BY REPORTING LOCATION

Reporting Location Nos.: - - -

Name/Identification of Location: _____

Name of Master Certificate Holder: _____

Type of Report:

☐ Original Report (Due March each year) ☐ Amended Report ☐ Interim Report

From

Date: Month Day Year To

Date: Month Day Year

A. CASES AND BENEFITS (to nearest dollar)

	Number	Incurred Liability		Paid to Date		Future Liability	
		\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
1. Cases open as of 12/31/2000 reported prior to 1996							
2. Open & Closed Cases:							
a. All cases reported in 1996							
1996 Cases open							
b. All cases reported in 1997							
1997 Cases open							
c. All cases reported in 1998							
1998 Cases open							
d. All cases reported in 1999							
1999 Cases open							
e. All cases reported in 2000							
2000 Cases open							
SUBTOTAL						\$ Indemnity	\$ Medical
TOTAL							
3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical)						\$ Indemnity	\$ Medical
4. Total Benefits paid during 2000 (including all case expenditures):							
5. Number of MEDICAL-ONLY cases reported in 2000:							
6. Number of INDEMNITY cases reported in 2000:							
7. TOTAL of 5 and 6 (also entered in 2e above):							
8. TOTAL number of open indemnity cases (all years):							
9. Number of Fatality cases reported in 2000:							
10. (a) Number of 2000 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 2000:							
10. (b) Number of non-2000 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 2000:							

A. NAME OF CURRENT ADMINISTRATOR(S)/ADMINISTRATING AGENCY(S) AT THE TIME OF PREPARING THIS REPORT.

1. Name (Person) _____

Administrative Agency's

Agency Name _____

Certificate No.:

Address _____

or Self Administered

City _____ State _____ Zip+4 _____

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD?

YES

NO

 IF YES, DATE OF CHANGE:

Month Day Year

TYPE OF CHANGE:

Change in Administrative Agency

Change to or from Self Administration

C. NAME OF PRIOR ADMINISTRATOR(S)/ADMINISITRATIVE AGENCY(S):

Name _____

Agency Name _____

Address _____

City _____ State _____ Zip+4 _____

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this consolidated report of this self insurer’s workers’ compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers’ compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers’ compensation claims made in this report reflect the administrator’s best judgment as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

Original Signature of Administrator (Person) _____

Typed Name of Administrator _____

Title _____

Date _____

Name of Administrative Agency or Employer _____

Street Address _____

City

State

Zip+4

Phone No. of Administrator ()

FAX No. ()

area code

area code

E-mail Address of Administrator _____

IV. RECORDS STORAGE

1. Are claim records stored at any location other than with the current administrator?

☐ Yes ☐ No If yes, Where? _____

A. Agency Name _____ Address _____ City _____ State ____ Zip+4 _____ Phone (____) _____	C. Agency Name _____ Address _____ City _____ State ____ Zip+4 _____ Phone (____) _____
B. Agency Name _____ Address _____ City _____ State ____ Zip+4 _____ Phone (____) _____	D. Agency Name _____ Address _____ City _____ State ____ Zip+4 _____ Phone (____) _____

V. INSURANCE COVERAGE

1. Are any of your workers' compensation liabilities in California during the reporting period covered by a standard workers' compensation insurance policy?

☐ Yes ☐ No If Yes: _____

1. Name of Insurance Company: _____ Policy Number: _____	Policy Issue Date: _____
2. Name of Insurance Company: _____ Policy Number: _____	Policy Issue Date: _____

2. Are any of your workers' compensation liabilities in California during the reporting period covered by a specific excess workers' compensation insurance policy?

☐ Yes ☐ No If Yes: _____

1. Name of Carrier: _____ Policy Number: _____ Retention Limit: _____	Policy Issue Date: _____
2. Name of Carrier: _____ Policy Number: _____ Retention Limit: _____	Policy Issue Date: _____

3. Do you carry an aggregate (stop loss) workers' compensation insurance policy?

☐ Yes ☐ No If Yes: _____

1. Name of Carrier: _____ Policy Number: _____ Retention Limit: _____	Policy Issue Date: _____
2. Name of Carrier: _____ Policy Number: _____ Retention Limit: _____	Policy Issue Date: _____

VI. OPEN INDEMNITY CLAIMS AND CLAIM LOG

A. List of ALL Open Indemnity Claims (by reporting location and by year) reported and with claims (in alphabetical order) is attached immediately following page 7 of this report.
(You may use the form attached or a computer-prepared printout organized in the same format.)

B. Specific Excess Insurance Policy Pages

ATTACHMENTS:

- 1. List of Open Indemnity Claims (See instructions under Section VI.)
- 2. Specific Excess Insurance Policy Pages

VIII. DEPOSIT CALCULATION

A. Estimated Future Liability

(From Line 3 of Consolidated Liabilities on Page 2).....

B. Minimum Deposit Factor—Known Claims

x 135%

Indicate Minimum Deposit Required

Line BB \$

C. Add Deposit for Current Year:

(1) Estimated Future Liability

(From Line A above) \$

(2) Less Future Liability of cases prior to 1996

(From Line 1 of Consolidated Liabilities on Page 2) - \$

\$ Indemnity	+	\$ Medical

(3) 5 year total unpaid Future Liability = \$

(4) One year average unpaid liability (Divide Line 3 above by “5”) ÷ 5 Line CC \$

(5) Subtotal (Add Line BB and Line CC) Subtotal \$

D. Total Adjustment for Excess Coverage

- \$

Adjusted Total Line DD \$

E. Total Deposit All Types (Line AA, Part VII, previous page) Line AA \$

Minimum Deposit Increase Indicated (Line DD—Line AA) \$

Increase is Due by May 1.

Minimum Deposit Decrease Indicated (Line DD—Line AA) \$ ()

NOTE: Labor Code Section 3701(a) requires every private, self-insuring employer to secure incurred liabilities for the payment of compensation by renewing or making a new deposit of security within 60 days of filing of this annual report, but in no event later than May 1 of each year. Civil penalties of up to \$5,000 for every 30 days or portion thereof that there is a failure to post deposit may be assessed by the Director of Industrial Relations pursuant to Labor Code Section 3702.9 for failure to post required deposit when due.

CERTIFICATE OF COMPANY OFFICER

I declare under the penalty of perjury that I have examined this Self Insurer’s Annual Report and to the best of my knowledge and belief it is true, correct and complete. I am also aware of our company’s duty to post and maintain the required security deposit that is due as a result of this report.

Signature of Company Officer

Typed Name of Company Officer

Title

Date

Name of Company

Street Address

City

State

Zip+4

Phone No. ()

area code

SPECIFIC EXCESS INSURANCE POLICY COVERAGE

Certificate No: _____ **Name of Self Insurer:** _____

Note: Instructions to Claims Administrator—See Reverse Side of this Page.

Name of Claimant	Claim No.	Date of Injury	First Year Reported To SIP
Description of Injury		Name of Specific Excess Carrier	
Policy Number	Policy Period		Employer's Retention \$:
	From:	To:	Upper Policy Limit \$:

Claim Reported to Carrier? ☐ Yes ☐ No

Claim Acknowledged/Accepted by Carrier? ☐ Yes ☐ No

Has carrier denied any part or all liability of this claim? ☐ Yes ☐ No

Total of payment by excess carrier to date of this claim: \$

Employer's Retention		Total Paid on Claim (Indemnity & Medical figures from Section VI)		Unpaid Employer Retention Enter "0" if "b." is greater than "a."	
1 a.	\$ <input type="text"/>	Minus b.	\$ <input type="text"/>	= c.	\$ <input type="text"/>
Estimated Future Liability on Claim (From Section VI)		Unpaid Employer Retention (Item c. above)		Total Unpaid Carrier Liability	
2 d.	\$ <input type="text"/>	Minus e.	\$ <input type="text"/>	= f.	\$ <input type="text"/>

Name of Claimant	Claim No.	Date of Injury	First Year Reported To SIP
Description of Injury		Name of Specific Excess Carrier	
Policy Number	Policy Period		Employer's Retention \$:
	From:	To:	Upper Policy Limit \$:

Claim Reported to Carrier? ☐ Yes ☐ No

Claim Acknowledged/Accepted by Carrier? ☐ Yes ☐ No

Has carrier denied any part or all liability of this claim? ☐ Yes ☐ No

Total of payment by excess carrier to date of this claim: \$

Employer's Retention		Total Paid on Claim (Indemnity & Medical figures from Section VI)		Unpaid Employer Retention Enter "0" if "b." is greater than "a."	
1 a.	\$ <input type="text"/>	Minus b.	\$ <input type="text"/>	= c.	\$ <input type="text"/>
Estimated Future Liability on Claim (From Section VI)		Unpaid Employer Retention (Item c. above)		Total Unpaid Carrier Liability	
2 d.	\$ <input type="text"/>	Minus e.	\$ <input type="text"/>	= f.	\$ <input type="text"/>

Name of Claimant	Claim No.	Date of Injury	First Year Reported To SIP
Description of Injury		Name of Specific Excess Carrier	
Policy Number	Policy Period		Employer's Retention \$:
	From:	To:	Upper Policy Limit \$:

Claim Reported to Carrier? ☐ Yes ☐ No

Claim Acknowledged/Accepted by Carrier? ☐ Yes ☐ No

Has carrier denied any part or all liability of this claim? ☐ Yes ☐ No

Total of payment by excess carrier to date of this claim: \$

Employer's Retention		Total Paid on Claim (Indemnity & Medical figures from Section VI)		Unpaid Employer Retention Enter "0" if "b." is greater than "a."	
1 a.	\$ <input type="text"/>	Minus b.	\$ <input type="text"/>	= c.	\$ <input type="text"/>
Estimated Future Liability on Claim (From Section VI)		Unpaid Employer Retention (Item c. above)		Total Unpaid Carrier Liability	
2 d.	\$ <input type="text"/>	Minus e.	\$ <input type="text"/>	= f.	\$ <input type="text"/>

SUBTOTAL Total Unpaid Carrier Liability This Page: \$ _____

Instructions to Claims Administrator

Complete all the information requested on each claim that has estimated incurred liability greater than the minimum retention level of the specific excess insurance policy.

Add the subtotaled carrier liability for all pages necessary to list the claims in excess coverage and then complete the back-side of this form on the last page of the specific excess insurance policy coverage pages in order to calculate the adjustment figure of Specific Excess Coverage to enter on Page 6, Line D of the Self Insurer’s Annual Report.

Submit the completed page or pages as Section B of the Part 6, List of Open Indemnity Claims, for each Annual Report.

Note: You may use this form or a computerized form displaying the same information in the same format.

Calculation of Specific Excess Coverage Entry for Annual Report:

1. Total of Carrier Liability Listed on All Pages of “Specific Excess Insurance Policy Coverage” pages attached hereto:

\$ _____
2. Enter Deposit Rate Applicable for This Self Insurer:

X

3. Multiply Line 1 Figure times Deposit Rate and Enter Specific Excess Insurance Adjustment:

\$ _____
4. Enter Adjustment Figure on Line 3 above on Page 6, Line D.

LIST OF OPEN INDEMNITY CASES
AS OF _____
(Date)

Reporting Location No.: _____
Certificate Number: _____

All Cases on this Page are
For the Year _____

NAME OF MASTER CERTIFICATE HOLDER: _____

Name of Insured or Deceased (Last) (First Initial)	Date of Injury	Description of Injury	Paid to Date		Estimated Future Liability	
			\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
(List Alphabetically within year)						